

# APRN RENEWAL APPLICATION

## MONTANA STATE BOARD OF NURSING

PO BOX 200513  
301 S PARK AVE  
HELENA MT 59620-0513  
406-841-2340

**Please print** (Illegible forms will not be processed):

Full Name \_\_\_\_\_  
Address \_\_\_\_\_ (street/PO Box, city, zip)  
Phone Number \_\_\_\_\_ (area code and number)  
License Type \_\_\_\_\_ RN \_\_\_\_\_ LPN  
License Number \_\_\_\_\_  
License Status \_\_\_\_\_ (e.g. active, inactive, active probation)  
Social Security Number (required) \_\_\_\_\_

**Your Current Montana license will expire on 12/31/2002.**  
**This is now a TWO YEAR Renewal.**

To practice as an APRN or to hold yourself out as an APRN in Montana, you must hold an active Montana APRN license.

Please complete this form. Renewals must be returned to our office promptly. Applications received after **December 15<sup>th</sup>** are not guaranteed for processing by December 31<sup>st</sup>. We are sincerely sorry that we were unable to offer online renewals for APRNs this year. We plan to have that system developed and operational by the 2004 renewal season.

To renew your license:

- 1) Complete the entire application FRONT AND BACK.
- 2) Answer all questions on the form. (includes DUIs, any other criminal charges in the discipline section)
- 3) **Sign and date the form.**
- 4) Choose licensure status by checking the correct box and submit a check or money order made payable to the Montana Board of Nursing based on your license status as checked below. If your check is returned to us for NSF, your license for the upcoming two years will be invalid and you will be charged **an additional administrative fee of \$50.00.**
- 5) Renewals with a US Postal Service postmark after December 31<sup>st</sup> will be assessed a penalty fee at double the rate of your license fees. **NO EXCEPTIONS!**
- 6) If you are renewing prescriptive authority, include an additional \$75 and verify continuing education on the back of this form.

- ☐ **Active Status:** Renewed by submitting a completed, signed renewal application and submitting \$150.00 for one specialty, plus \$50.00 for each additional specialty, by December 31<sup>st</sup>. You must have an active license to work in Montana as a nurse or to hold yourself out as a nurse.
- ☐ **Inactive Status:** Renewed by submitting a completed renewal application form and checking the inactive option. This option is for nurses who are currently not employed, retired or living out of state. The fee is \$70.00 total for a two year period (for RN and APRN Inactive Status). You will **not** receive a license in the mail and you may **not** practice nursing or hold yourself out as a nurse, but you will continue to receive newsletters and a license renewal form in 2004. You may request a renewal form anytime during the next two years to change to Active Status and by submitting a payment required to total that of an active license for your specialty(ies).
- ☐ **Lapsed License:** If you are not currently working in nursing, you have the option to let your license lapse. You may hold a lapsed license for a period of no more than 3 years, unless you hold an active license in another U.S. jurisdiction. If you fail to activate your license after being lapsed for 3 years, and do not hold a current active license in another state, you would have to complete a Montana application to re-establish licensure. At this time we would require a written request to receive the appropriate forms to be completed and submitted with the appropriate fees. Lapsed licensees do not receive the newsletters or bi-annual renewal forms.

### **REQUIRED:**

Yes \_\_\_ No \_\_\_ **Have any legal or disciplinary actions been instituted against you since your renewal?** If so, please attach copies of the document that initiated each action and all final orders. Mont. Code Ann. Sec. 37-1-105 requires that you report this information. Failure to accurately furnish the information is grounds for denial or revocation of your license.

### **REQUIRED:**

I hereby declare under penalty of perjury the information included in my renewal application to be true and complete to the best of my knowledge. In signing this renewal application, I am aware that a false statement may lead to disciplinary action against my license. The Board may audit my records to verify my compliance with the rules and regulations governing this license. I have read and am familiar with the laws and rules of the State of Montana relating to nursing and agree to comply with them.

**YOUR SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

(Rev. 8/02)

# MONTANA STATE BOARD OF NURSING

## APRN SWORN STATEMENT UNDER PENALTY OF PERJURY

### MUST BE TYPED

I \_\_\_\_\_, acknowledge that I am licensed in Montana as a  
*Name as it appears on your license*

\_\_\_\_\_ and as such, thoroughly understand and work within the professional scope of standards  
*Certification*

of my credentialing body and that of the State Board of Nursing. I work at the following site(s):

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Physical Address

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Physical Address

TYPICAL CASELOAD: (Type of patients, number per month, presenting problems, types of care provided)

TYPE	# PATIENTS/MONTH	PRESENTING PROBLEMS	TYPE OF CARE

\_\_\_ I am not working in a direct patient care position. Explain. \_\_\_\_\_

Availability of other health care providers:

\_\_\_ Joint Practice with \_\_\_\_\_ # Physicians \_\_\_\_\_ APRNs \_\_\_ Independent Practice \_\_\_ Other

Explain \_\_\_\_\_

I have a referral process method.

I have quarterly quality assurance reviews performed on my client records, and I maintain proof of such in my office. My reviewer's (s) name is/are \_\_\_\_\_ and I will send the Board office a copy of the reviewer's signed statement should you be selected for a random audit during the next 2 years.

I agree to monitor patient outcomes and follow up appropriately as recommended by scope and standards of my practice. When patient outcomes do not meet acceptable standards, I take immediate and appropriate actions to improve that area of my practice.

I understand that the Board office may request an audit report at any time to evaluate my compliance with my quality assurance plan. I agree to maintain my quality assurance records for a period no less than five years.

If I have prescriptive authority; I prescribe only within my specialty and scope, and I validate the need for each prescribed medication in the client record. I have taken 6 hours of continuing education in pharmacotherapeutics within the last two years. Two hours have were in a face to face presentation.

I will notify the Board office of any changes I make within the next year in writing on the designated Board form. I will send the Board a copy of my certification if it is renewed during this year.

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APRN signature

Date